

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 001132	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 09/30/2016
NAME OF PROVIDER OR SUPPLIER INDEPENDENT LIVING CLUB		STREET ADDRESS, CITY, STATE, ZIP CODE 6038 W 25TH ST INDIANAPOLIS, IN 46224		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaints IN00200918 and IN00207138 completed on 8/22/16.</p> <p>This visit was in conjunction with the PSR to the State Residential Licensure Survey completed on 5/11/16.</p> <p>Complaint IN00200918 - Corrected.</p> <p>Complaint IN00207138 - Corrected</p> <p>Survey dates: September 29 & 30, 2016</p> <p>Facility number: 001132 Provider number: 001132 AIM number: N/A</p> <p>Residential Census: 33</p> <p>Sample: 4</p> <p>Independent Living Club was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the Investigation of Complaints IN00200918 and IN00207138.</p> <p>Quality Review was completed by 21662 on September 4, 2016.</p>	{R 000}		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE